STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004975	A. BUILDING _____ B. WING _____	10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT CATHERINE REGIONAL HOSPITAL	2200 MARKET ST CHARLESTOWN, IN 47111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for one (1) State complaint investigation. Date of survey: 10/19/11 Facility number: 004975 Complaint number: IN00096024 Unsubstantiated; lack of sufficient evidence Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Saint Catherine Regional Hospital is in compliance with 410 IAC 15-1.5-8, Physical Plant, 410 IAC 15-1.5-2, Dietary and 410 IAC 15-1 5-6 Nursing Services, Hospital Licensure Rules. QA: claughlin 11/02/11	S 000		